to the theory, this phase-advancing of the melatonin cycle is what causes clinical remission in these patients.

Others, however, point out that many of these patients show improvement if given light in the middle of the day or in the evening—times at which melatonin secretion is virtually nil and when light would not cause a phase-advance in melatonin circadian rhythms. The mechanism by which bright light causes clinical effects must therefore be due to another nonmelatonin pathway. At present, no satisfactory explanations for this midday effect exist.

Questions on how best to administer light partly hinge on the explanation used. Proponents of the phase-shift theory recommend that light be given in the early morning, but others think that the timing of the light—morning versus evening versus afternoon—is probably irrelevant. At least 2,000 and preferably 2,500 lux of light is necessary. With the "light boxes" commercially available, patients need to sit 1 m (3 ft) from the light source. No room lights are ever bright enough to cause clinical improvement. Most investigators recommend that at least two hours of light be administered daily. A clinical response is typically seen within days to one week, faster than responses seen with the use of antidepressants. If the light therapy is discontinued while patients are still vulnerable to depression (typically before March or April), they frequently relapse quickly, usually within days.

Current research is focusing on psychopharmacologic treatments of seasonal affective disorder, the use of light for nonseasonal depressions, and further clarification of light's therapeutic mechanism of action.

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Intractable Depression in Tertiary Care

ALMOST ALL STUDIES of antidepressant use show a consistent response rate of 60% to 70%. Such results are achievable with the first or second trial of standard heterocyclic antidepressants, if therapeutic doses are achievable and the medication trial lasts four to six weeks. An apparent nonresponse should first be addressed by reevaluating for depressogenic factors, especially concurrent medication use—clonidine hydrochloride, β-blockers, methyldopa, reserpine, and birth control pills—and occult hypothyroidism. Blood concentrations provide useful information for only a few antidepressants—nortriptyline hydrochloride, imipramine hydrochloride, desipramine hydrochloride—because of the paucity of well-controlled studies. Once the above considerations have been met, patients can be defined as treatment resistant, and a systematic approach for subsequent interventions is then required. The following treatment regimen should be considered: adding lithium carbonate, adding a stimulant, the use of a monoamine oxidase inhibitor, the use of alprazolam, and electroconvulsive therapy. There are no modern studies that directly compare the relative efficacy of these interventions for intractable depressions—other than electroconvulsive treatment and monoamine oxidase inhibitors—so the choice of order is left to clinical judgment. Lithium is added to the heterocyclic antidepressant therapy at dosages needed to achieve therapeutic serum concentrations—about 0.5 to 1.0 mEq per liter—or at some centers a standard 900 mg per day is used. From 30% to 50% of patients may be expected to respond over a period of four to six weeks of combined treatments, are maintained on both for the usual 9 to 12 months, and then the dosages are tapered.

A monoamine oxidase inhibitor may be either added to, or used instead of, a heterocyclic antidepressant. Two such drugs, phenelzine sulfate or isocarboxazid, are now commonly added to a heterocyclic antidepressant regimen, but combinations with tranylcypromine sulfate have been associated occasionally with adverse effects. More than 70% of patients who apparently do not respond to heterocyclic antidepressant medication have been responsive if adequate dosages of monoamine oxidase inhibitors are used, such dosages commonly exceeding 75 mg a day of phenelzine or 50 mg a day of isocarboxazid or tranylcypromine.

Although there are few double-blind trials, many recent case series document the efficacy and safety of stimulants as antidepressant agents. This is particularly so for patients with medical illnesses, where response rates may approach 70%. Side effects are remarkably rare, as is any tendency for patients to abuse the agents. The common dosage range of methylphenidate is 5 to 20 mg twice a day and of amphetamine, 2.5 to 15 mg twice a day. They commonly are added to a regimen of heterocyclic antidepressants and may decrease the incidence of the development of tolerance.

Several large well-controlled studies have found alprazolam to be effective for depression at mean dosages of 3.0 mg per day, with a wide variance. Improvement occurred over three to six weeks. While alprazolam does not have the common heterocyclic side effects on the cardiovascular system and parasympathetic systems, its dosage should be tapered slowly to avoid possible withdrawal symptoms.

Electroconvulsive therapy appears to be the modern treatment of choice for severe or intractable depression, with typical response rates of 90% using modern computerized equipment. Accepted practice now would include it as an early intervention before all possible pharmacotherapeutic combinations are tried.

The adjunctive use for an antidepressant response of tryptophan, phenylalanine, thyroid hormone, estrogen, reserpine, yohimbine, and carbamazepine is not yet well documented.

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Reporting Elder Abuse

ALTHOUGH ESTIMATES on the prevalence of elder abuse vary, it is thought to be at least as common as child abuse. Victims are typically older than 75 years, women, and either physically or mentally disabled. Victims of abuse often come to